

Thank you for choosing Dr J. Roach, D.O. We are committed to providing you with the best medical care possible. Please review a brief explanation of our policies & procedures below. After you have read this document in its entirety, please sign. Your signature constitutes a binding legal contractual agreement to the procedures and policies of our practice.

FINANCIAL POLICIES AND PROCEDURES

We believe that all patients who come to this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must insure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy and contractual agreement between the patient and physician.

ANTI-BLOG CONTRACTUAL AGREEMENT

We believe that all our patients deserve confidential private care. As we do not discuss any patient information with any third party, we also expect that patients will likewise hold the care they receive in confidence. By signing this agreement, you, the patient, agree not to engage, discuss or otherwise disseminate, directly or indirectly, any fact or opinion relative to the physician and/or staff services rendered hereunder to any third party without prior written consent from the physician or physician's authorized agent. Examples of third parties include any internet physician review, blog, web page, newspaper, email, or any other related venue. These third parties are illustrative and are by no means offered as an exhaustive list. Furthermore, you understand and agree that your breach of this Confidentiality Agreement shall be subject to all civil remedies permitted by law.

DEFINITIONS

OUT OF NETWORK/ NON-PARTICIPATING INSURANCE: If we are not in network with your insurance carrier, we will bill your carrier as a courtesy. If payment is not received within 60 days, the balance becomes your responsibility. You will have to contact your insurance company to determine why payment has not been made. Please be aware, you may incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check with your insurance company for your benefits with your insurance company.

ACCEPT ASSIGNMENT DEFINITION: Accept assignment means that we agree to accept check payment from the insurance company for services rendered.

PAYMENT AT TIME OF SERVICE

As a courtesy, we will bill your insurance for all office visits. However, we ask that you pay any portion not covered by your insurance due to deductibles or co-payments on the day of service, unless otherwise specified in specific policies.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts Visa, MasterCard, American Express, and Discover. Our office also accepts check or cash. There will be a \$20 fee for all returned checks. We also accept Care Credit, please inquire about it at the Reception Desk.

NON-COVERED SERVICE

OUT OF NETWORK/ NON-PARTICIPATING INSURANCE/NON-COVERED SERVICE: We do not accept insurance for this type of surgical procedure and therefore we will need immediate payment prior to any planned surgical procedure.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the 20 percent at the time of service.

MOTOR VEHICLE ACCIDENT

Auto insurances will be billed as a courtesy to you. If no payment is received within 30 days, the balance is your responsibility. Please provide us with your claim information and any copies pertaining to the accident.

BILLING PROCEDURE

You will receive a statement with your remainder balance once a reply is received from your insurance company. Payment to you by your Insurance Company is a possibility, if this occurs you agree to sign over the payment to Dr. Roach at the office address. If you fail to do this you may be subject to any fees incurred in tracking this payment which could include court/Attorney fees.

CANCELLATION FEES

Please note that after full payment has been received for any planned procedure there will be a cancellation fee. If the cancellation is within 7 days of the scheduled date of surgery there will be no refund. If the cancellation is greater than 7 days there is a one thousand dollar cancellation fee. There is a \$75.00 cancellation fee for missed appointments. Being more than 15 minutes late is considered a late cancellation and is subject to the same fee.

COMPLETION OF FORMS AND COPY CHARGES

There is a \$25.00 fee for each form that needs to be completed. Please allow 7 days for this form to be completed. Expedited forms (within 24 hours) will be \$50.00. Copying charges are \$1.00 per page.

Please sign below to acknowledge that you have read our Policy

X_____